



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE:** Information about the cost of this plan (called the premium) will be provided separately. This is only a **summary**. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.dhrm.virginia.gov or by calling 1-888-642-4414. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-855-414-1901 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	For each <u>Plan</u> Year, In- <u>Network</u> : Individual \$1,500 / Family \$3,000. Out-of-Network: Individual \$3,000 / Family \$6,000.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . A Health Reimbursement Arrangement (HRA) is available that works with your medical <u>plan</u> , as described in your employer's Member Handbook.
Are there services covered before you meet your <u>deductible</u>?	Yes. In- <u>network</u> <u>preventive care</u> is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	In- <u>Network</u> : Individual \$3,000 / Family \$6,000. Out-of-Network: Individual \$6,000 / Family \$12,000.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover & out-of-pocket costs for dental & vision.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.aetna.com/docfind or call 1-855-414-1901 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	40% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. Age & frequency schedules may apply.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.aetnapharmacy.com/premier Premier Formulary	Generic drugs	20% <u>coinsurance</u> (retail & mail order)	40% <u>coinsurance</u> (retail)	Covers up to a 90 day supply (retail & mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic & single source brand FDA-approved women's contraceptives <u>in-network</u> . Pre-cert and step therapy apply with 90 day TOC. Your cost will be higher for choosing Brand over Generics.
	Preferred brand drugs	20% <u>coinsurance</u> (retail & mail order)	40% <u>coinsurance</u> (retail)	
	Non-preferred brand drugs	20% <u>coinsurance</u> (retail & mail order)	40% <u>coinsurance</u> (retail)	
	<u>Specialty drugs</u>	20% <u>coinsurance</u> (retail & mail order)	40% <u>coinsurance</u> (retail)	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u> for out-of-network non-emergency use.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u> for non-emergency transport.
	<u>Urgent care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Pre-authorization</u> required for out-of-network care.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: 20% <u>coinsurance</u>	Office & other outpatient services: 40% <u>coinsurance</u>	None
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Pre-authorization</u> required for out-of-network care.
If you are pregnant	Office visits	No charge	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) <u>Pre-authorization</u> for out-of-network care may apply.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	90 visits/ <u>plan</u> year. <u>Pre-authorization</u> required for out-of-network care.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to children from 2 years up to age 10 for Autism.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	180 days/confinement. Separated by 90 days, a new allotment allowed. If not separated by 90 days subject to prior limit. <u>Pre-authorization</u> required for out-of-network care.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Pre-authorization</u> required for out-of-network care.
If your child needs dental or eye care	Children's eye exam	No charge	0% <u>coinsurance</u>	1 routine eye exam/ <u>plan</u> year.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	No charge	No charge	2 routine dental exams/ <u>plan</u> year.

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none">• Acupuncture• Cosmetic surgery• Dental care (Adult & Child)	<ul style="list-style-type: none">• Glasses (Child)• Hearing aids• Long-term care	<ul style="list-style-type: none">• Routine foot care• Weight loss programs - Except for required preventive services.
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none">• Bariatric surgery• Chiropractic care - 30 visits/plan year.	<ul style="list-style-type: none">• Infertility treatment Limited to diagnosis & treatment of underlying medical condition• Non-emergency care when traveling outside the U.S. - Covers all medically necessary emergency & non-emergency services.	<ul style="list-style-type: none">• Private-duty nursing• Routine eye care (Adult) - 1 routine eye exam/plan year not including glasses.

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: The Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, contact: Director, Department of Human Resource Management, 101 North 14th Street, 12th Floor, Richmond, VA 23219-3657. Mark envelope Confidential- Appeal Enclosed. Telephone: 1-888-642-4414.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan Meet Minimum Value Standard? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

-----To see examples of how this plan might cover costs for a sample medical situation, see the next section.-----

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist Coinsurance</u>	20%
■ Hospital (facility) <u>Coinsurance</u>	20%
■ Other <u>Coinsurance</u>	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
In this example, Peg would pay:	
<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$1,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,060

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist Coinsurance</u>	20%
■ Hospital (facility) <u>Coinsurance</u>	20%
■ Other <u>Coinsurance</u>	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
In this example, Joe would pay:	
<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$1,100
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,620

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist Coinsurance</u>	20%
■ Hospital (facility) <u>Coinsurance</u>	20%
■ Other <u>Coinsurance</u>	20%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
In this example, Mia would pay:	
<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$90
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,590

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-888-642-4414.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-855-414-1901.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),

1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705),

Email: CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

Language Assistance:

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-855-414-1901.
Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-855-414-1901 በነጻ ይደውሉ
Arabic -	1-855-414-1901 للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-855-414-1901 առանց գնով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-855-414-1901 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-855-414-1901 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-855-414-1901-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-855-414-1901 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-855-414-1901 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-855-414-1901.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-855-414-1901 sin gåstu.
Cherokee -	ΘαδΥΘ ϜΨhθωΔ JhωδSPωδΥ ΘεT (GWY) @BWδ°i\$ 1-855-414-1901 O'OT L AΓωΔ JEGPJ hPRΘ.
Chinese -	欲取得繁體中文語言協助，請撥打 1-855-414-1901，無需付費。
Choctaw -	(Chahta) anumpa ya apela a chi l paya hinla 1-855-414-1901.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-855-414-1901 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-855-414-1901.
French -	Pour une assistance linguistique en français appeler le 1-855-414-1901 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-855-414-1901 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-855-414-1901 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-855-414-1901 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-855-414-1901 પર કોલ કરો.

Hawaiian -	No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-855-414-1901. Kāki ‘ole ‘ia kēia kōkua nei.
Hindi -	हन्दि में भाषा सहायता के लएि, 1-855-414-1901 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-855-414-1901.
Ibo -	Maka enyemaka asụsụ na Igbo kpọọ 1-855-414-1901 na akwụghị ụgwọ ọ bụla
Ilocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-855-414-1901 nga awan ti bayadanyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-855-414-1901.
Japanese -	日本語で援助をご希望の方は、1-855-414-1901 まで無料でお電話ください。
Karen -	လၢတၢ်မၤစၢၤတၢ်ကတိၤကျိၣ်အံၤ ကျိၣ် ကိး 1-855-414-1901 လၢတၢ်အိၣ်ဒီးတၢ်လၢၢ်သ့ၣ်လၢၢ်စ့ၤသ့ၣ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862번으로 전화해 주십시오.
Kru-Bassa -	Ḑe m'ké gbo-kpá-kpá dyé pidiyi dé Ḑaśwó-wuḏuūn wěɛ, dǎ 1-855-414-1901
Kurdish -	برای راهنمایی به زبان فارسی با شماره 1-855-414-1901 به خۆرای یه یۆمندی بکەن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-855-414-1901 ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi -	तीलभाषा (मराठी) सहाय्यासाठी 1-855-414-1901 क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-855-414-1901 ilo ejjelok wōnān.
Micronesian-Pohnpeyan -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-855-414-1901 ni sohte isais.
Mon-Khmer, Cambodian -	សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទទេៅកាន់លេខ 1-855-414-1901 ដោយឥតគិតថ្លៃ។
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-855-414-1901
Nepali -	(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1- 855-414-1901 मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tèn kuwoɲy ë thok ë Thuonjäng col 1-855-414-1901 kec'in ayöc.
Norwegian -	For språkassistanse på norsk, ring 1-855-414-1901 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-855-414-1901 ‘ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Hefle in Deitsch, ruf: 1-855-414-1901 aa. Es Aaruf koschtet nix.
Persian -	برای راهنمایی به زبان فارسی با شماره 1-855-414-1901 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-855-414-1901.

Portuguese -	Para obter assistência linguística em português ligue para o 1-855-414-1901 gratuitamente.
Romanian -	Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-855-414-1901
Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-855-414-1901.
Samoan -	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-855-414-1901 e aunoa ma se totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-855-414-1901.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-855-414-1901.
Sudanic-Fulfude -	Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-855-414-1901. Njodi woo fawaaki on.
Swahili -	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-855-414-1901 bila malipo.
Syriac -	ܠܚܥܠܐ ܕܥܝܢܐ ܕܡܕܢܬܐ ܕܡܕܢܬܐ ܕܡܕܢܬܐ ܕܡܕܢܬܐ ܕܡܕܢܬܐ 1-855-414-1901 ܕܡܕܢܬܐ.
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-855-414-1901 nang walang bayad.
Telugu -	భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-855-414-1901 కు కాల్ చేయండి. (తెలుగు)
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-855-414-1901 ฟรีไม่มีค่าใช้จ่าย
Tongan -	Kapau ‘oku fiema’u hā tokoni ‘i he lea faka-Tonga telefoni 1-855-414-1901 ‘o ‘ikai hā ʻōtōngi.
Trukese -	Ren ánninnisin chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-855-414-1901 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemedен 1-855-414-1901.
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-855-414-1901.
Urdu -	اگر آپ کو کسی زبان کی مدد کی ضرورت ہے تو 1-855-414-1901 پر بلا کوئی خرچہ کیے بغیر کال کریں۔
Vietnamese -	Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-855-414-1901.
Yiddish -	פאר שפראך הילף אין אידיש רופט 1-855-414-1901 פאר א פאפולערע.
Yoruba -	Fún ìrànṣẹ̀wọ̀ nípa èdè (Yorùbá) pe 1-855-414-1901 láí san owó kankan rárá.